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### CLINICAL LECTURES.

#### ON PARACENTESIS OF THE PERICARDIUM, WITH A SUCCESSFUL CASE.

By WILLIAM PEPPER, A.M., M.D.,  
Professor of Clinical Medicine in the University  
of Pennsylvania.

GENTLEMEN: You will remember that, in connection with two cases of pericarditis of moderate severity, which formed the subject of a lecture several months ago, I referred to a desperate case of pericarditis, with effusion, in which it had been necessary to perform paracentesis. My chief object to-day, in returning to the same subject, is to report at

length the latter case, and to make a few practical remarks in connection with that operation.

*Rapid Pericardial Effusion; Albuminuria; Uramic Convulsions; Paracentesis Pericardii, with immediate relief; Jabourendi; Recovery; Subsequent disease of other serous membranes.*—Sarah C., æt. 17, a well-developed girl, enjoying general good health, had noticed since May, 1877, some shortness of breath on exertion, especially after mounting the long flights of stairs leading to the fringe factory where she worked. She had also been obliged to pass urine more frequently than usual. She had never mentioned either of these symptoms to her parents, fearing that they would make her stop working. In early childhood she had

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passed through a mild attack of measles; but had never had any other exanthem or rheumatism. On Sunday, September 2, she suffered with præcordial pain. No cause could be assigned for the attack, unless it were that she had been chilled by a draft which blew upon her as she worked. On Monday the pain continued with some sense of oppression. She did not leave the house, but it was not until Wednesday, September 5, that she became quite suddenly so ill as to confine her to bed, when she was seen by Dr. George A. Rex, with whom I saw the case in consultation, and to whose courtesy I am indebted for many of the facts in connection with it. He found her with a very moderate degree of fever, but with some anxiety and distress, and with rapid pulse, frequent breathing, and severe præcordial pain. By Friday, September 7, she was much worse. There was still severe præcordial pain, with great restlessness and distress. The respiration was very frequent and much laboured. The pulse was extremely rapid, feeble, and irregular. The apex beat of the heart was felt with difficulty, and the sounds were feeble and distant, though apparently without valvular murmur. The area of cardiac dullness was increased. The tongue was moist and somewhat furred. The stomach was retentive, though there was no appetite. The urine was rather scanty. From time to time there were paroxysms of terrible dyspnoea and cardiac distress, in some of which she seemed almost asphyxiated. Her condition became, in all respects, somewhat worse during Saturday and Sunday, and, in addition, there were on the latter day two convulsive attacks, with loss of consciousness for a few minutes, and slight muscular spasms of the face, arms, and legs.

I saw her in consultation with Dr. Rex, first on Sunday night, September 9. The patient was lying in bed, with but a single pillow under the head. The face was very pale, and the lips livid; the extremities tended to be cold. There was extreme restlessness and jactitation, with a sense of suffocation if any one even approached her. It was necessary to fan

her constantly. The respirations were over 60; the pulse at least 145, very small, feeble, and intermittent. The pupils were dilated; the expression very anxious; the intelligence clear. There were constant complaints of severe præcordial pain. The paroxysms of alarming dyspnoea were now very frequent. On physical examination no lesion of the lungs was found. The præcordia was somewhat prominent. The impulse of the heart could neither be seen nor felt, and its sounds were barely audible, being distant and feeble, and apparently without murmur. The point of their greatest intensity was at mid-sternum, opposite the third interspace. At the normal position of the apex-beat no sounds were audible. No friction sounds were heard. The area of cardiac dullness was much enlarged, and of rudely triangular shape. Its base was on the level of the seventh rib, and extended from one inch to the right of the sternum to two inches to the left of the line of the left nipple; the upper limit of the dullness was the second interspace. Its greatest transverse diameter corresponded to the level of the fifth interspace. Changes in the position of the patient's body produced no effect on the horizontal lines of dullness.

The urine contained a slight trace of albumen, and microscopic examination showed a few fragmentary hyaline or granulo-hyaline tube-casts, and a few cells of renal epithelium. There was no oedema of any part, save a slight puffiness about the ankles. The question of tapping the pericardium was discussed, but the parents would not consent. She had been using digitalis and a diuretic mixture. These were continued, ten drops of digitalis being given every three hours. A blister four inches square was applied over the præcordia. She objected violently to stimulants, even in very small doses, asserting that they immediately caused agitation of the heart, with great distress in the head. On the other hand, Hoffmann's anodyne gave some relief to the paroxysms. During Monday and Tuesday (September 10 and 11) she grew worse, if possible, and had several slight convulsive attacks. I saw her again with

Dr. Rex, late on Tuesday night. She was then dull and listless, with livid lips, and cold extremities. The respirations were mere shallow gasps, 75 to 80 in the minute. The pulse was over 160, extremely thready, and very intermittent. At times, also, the respirations were distinctly of tidal character, ascending and descending, with marked intermissions. Each paroxysm of dyspnoea seemed as if it would prove fatal, and it seemed clear that death would occur before morning. The consent of the parents being obtained, I immediately performed paracentesis of the pericardium, with the assistance of Dr. Rex and of Dr. C. B. Nanorede. The smallest needle-pointed canula of Dieulafoy's aspirator was employed, with a vacuum jar. The puncture was made in the fifth intercostal space, about one inch inside of the line of the left nipple, *i. e.*, nearly in the normal position of the apex-beat. The needle was introduced in a direction upwards and inwards. As soon as its extremity was fully covered by the soft tissues, the communication with the vacuum jar was opened, and the needle was cautiously pushed onwards. When the liquid began to flow into the jar, and the point of the needle was felt to be free in the pericardial sac, the needle was directed somewhat downwards and outwards. Rather more than eight fluid-ounces of reddish serum were removed, after which the flow ceased. The serum contained a very large proportion of albumen, many red-blood globules, and a large proportion of pseudo-fibrin. No difficulty whatever was encountered in the operation. Once or twice the point came in contact with a firm and apparently roughened surface, which was probably the apex of the heart, coated with lymph. The effect of the operation was magical. The pulse fell to 114, became regular, and much more full. The respirations soon fell to 40, and became much more deep and regular. The apex-beat of the heart could be felt, though still feeble and too high up. The cardiac sounds became immediately much more distinct. The lips grew more red, and the expression improved vastly. She expressed herself as feeling much better,

and able to lie quietly. She was ordered iodide of potassium gr. v, and tincture of digitalis gr. x, each every four hours. The diet of skimmed milk was continued. There was no evidence of any return of pericardial effusion, and for two days she continued very comfortable, although the urine was still faintly albuminous. On Friday, September 15, two severe convulsions occurred; the mind grew dull; the respirations again became rapid, and tidal in character; and the pulse intermittent. On September 16 she continued in a partially uræmic state, with several convulsions. Still, no sign of increased pericardial effusion occurred; but, on the other hand, the area of dullness progressively diminished, and the impulse and the sounds became more distinct. On the evening of this day an enema of infusion of jaborandi (3j of powdered leaves in  $\frac{3}{4}$ iv water) was given. The effects were rapid and marked—violent headache, repeated vomiting, copious salivation, and drenching sweat, lasting six or seven hours. She passed a more quiet night, and was better the following day. The pulse was now regular, and more full—108 in the minute; and the breathing easier. The cardiac impulse and sounds more distinct, and slight friction sound audible. The use of digitalis, iodide of potassium, and diet of skimmed milk, continued.

She had two convulsive attacks on September 17, and on September 18 three severe attacks, in all of which she was unconscious, with frothing at the mouth, and general convulsive movements. The cardiac symptoms continued to improve. There was a trace of albumen in the urine, but no tube-casts could be discovered.

On September 19, a second enema of infusion of jaborandi was given with the same prompt and severe effect. No further convulsions occurred. The cardiac symptoms improved slowly but steadily. There was no severe dyspnoea after September 28. She was able to leave bed on October 7, twenty-six days after the operation. On October 14, thirty-three days after the operation, she was still pale and weak, though able to be out of

bed all day, and to walk about slowly. Respiration was quiet and regular; the lungs were free from any congestion. The pulse was regular and quiet, though easily disturbed by exertion. The præcordia was not prominent. The point of puncture could barely be detected. The apex-beat was feeble, but distinct; it was at the lower border of the fifth rib, midway between the sternum and the line of left nipple. There was neither thrill nor recession of the soft intercostal tissues. No tenderness on pressure existed. The sounds of the heart were still weak, but quite distinct and free from murmur. There was no friction sound, save over the base of the heart where a slight pericardial clicking sound was audible. The area of cardiac dulness was nearly, if not quite, reduced to the normal dimensions. She complained of no palpitation or sense of oppression. The appetite was fair, and some solid food had been taken, although milk was still the chief article of diet. The urine was free, contained no albumen (Heller's test, and heat and nitric acid), and deposited a delicate sediment, containing vesical epithelium, but no tube-casts.

On February 2, 1878, nearly five months after the operation, I again saw the patient in consultation with Dr. Rex. Until the middle of December, the use of a milk diet, and of occasional doses of iodide of potassium, was continued, and the patient's condition remained very good. But in about five weeks, she began to suffer with pain about the chest and in the abdomen. The circulation was at times considerably disturbed. Soon the abdomen began to enlarge, and extensive ascites appeared, followed by œdema of the legs. At one time there was a troublesome vesical catarrh, but otherwise the urine continued normal. The milk diet, and the use of iodide of potassium, was resumed; and improvement soon showed itself. At this date (February 2) the patient is sitting up and quite comfortable. On careful examination of the præcordia there is no extension of area of dulness; the apex-beat is distinctly felt in the normal position; and the cardiac sounds are distinct,

though weak, and without either valvular murmur or friction sound. There is no dimpling of the intercostal tissues with the action of the heart, nor any fremitus on palpation.

Over both sides of the chest there is strong, coarse, pleuritic rubbing, evidently due to a small amount of plastic exudation, as there is no dulness on percussion, nor marked enfeebling of the respiratory murmur. There is considerable distension of the abdomen, with distinct fluctuation on palpation. There is some œdema of both legs, but much less than a few weeks ago. The amount of dropsy has greatly diminished, and the general condition of the patient has improved since resumption of milk diet and iodide of potassium.

*Remarks.*—It will be seen that in this case the preservation of life was solely due to the operation of paracentesis. It seemed abundantly evident that, on the evening of September 11, without immediate operative relief, life could not be supported through the night. The renal complication which existed was probably due to the pericarditis and, after the heart's action was liberated, it became possible to deal successfully with the uræmic symptoms. In this connection, it is interesting to note the great value of jaborandi. We have in this remarkable drug a new agent of vast power for the relief of such symptoms. After the operation, there was not the least sign of any return of pericardial effusion, and, although it is probable that adhesions have formed, there are no evidences at present that the heart's action is embarrassed by them. So far as the original disease is concerned, it may be said that a complete cure was effected. The subsequent attacks of subacute peritonitis and of plastic pleurisy indicate a constitutional character for all of the successive affections of the serous membranes, and I fear that it may prove that they have been tuberculous.

I have narrated this case in great detail, because the operation of paracentesis of the pericardium must still be considered as a debatable subject. It was only natural that, with the vast extension lately given to the performance

of paracentesis thoracis, an increased amount of attention should be bestowed upon the former operation. Nor is it surprising, when we recall the widely different views held as to the conditions suitable for paracentesis thoracis, and as to the advantages to be hoped for from that operation, to find a very wide diversity of opinion as to the propriety and mode of performance of paracentesis of the pericardium. I shall not dwell upon the history or statistics of this latter operation, because it happens that very recently these points have been made the subject of able and exhaustive memoirs.<sup>1</sup>

I may mention, however, that Roberts has collected forty cases,<sup>2</sup> and that since the date of his publication three others had been reported,<sup>3</sup> which, with my own case, brings up the total number to forty-four. Of these, only four have been in America. The first of these was operated on by Dr. J. C. Warren, in 1852, and Dr. H. H. Smith (*Syst. of Surgery*, vol. ii. p. 307) who quotes the case, states that he learned, on personal inquiry from Dr. Warren, that the patient recovered sufficiently to leave the hospital in a few weeks, after which he was not heard of. The second operation was performed by Dr. Lyon, in 1874 (*loc. cit.*). The case was one of pericarditis with purulent effusion, secondary to pneumonia; paracentesis was performed twice, at intervals of seven days, but death occurred on the sixteenth day after the first operation. The third was by Dr. Welch (*loc. cit.*), and also terminated fatally in a few days. I have already shown that the case attributed to Dr. Bowditch never occurred, so that the

operation I have above described is the fourth instance in this country, and the second in which the operation has been followed by success.

I have long been satisfied, upon theoretical grounds as well as from a knowledge of the results of the operation in those cases where it has been performed, that paracentesis of the pericardium is justified, and even imperatively demanded under certain conditions. Thus, of the 44 cases on record, 20 may be regarded as successful—a rate of mortality of about 55 per cent. It must be remembered, too, that in all of these cases the operation was performed when the patient was almost moribund; and, moreover, that, in the large majority, the pericarditis was either part of a general and incurable disease, or else was complicated by the coexistence of some other serious affection. Under no circumstances has the operation, if properly performed, been productive of any injurious effects; even in the most hopelessly unfavourable cases it has afforded great relief; while, if regard be had only to the comparatively uncomplicated cases, the ratio of complete and lasting recoveries is very high—certainly not less than 60 to 65 per cent. It must be admitted, therefore, I think, that paracentesis pericardii is a justifiable operation; and it consequently becomes very important to determine under what circumstances its performance is called for, and what is the best method of operation. I shall try to show you that, if a correct diagnosis of extensive pericardial effusion has been made, the operation itself is attended with but little difficulty or danger; and, consequently, the primary indication for paracentesis may be stated to be a liquid effusion in the pericardial sac, which has not yielded to a thorough employment of other modes of treatment, and which is causing such grave disturbances of circulation and respiration as to urgently threaten life. It is impossible to define the amount of effusion which may cause such symptoms, and thus call for operative interference. In cases where it has been formed gradually, enormous quantities (one, two, or even four quarts) of liquid may be tole-

<sup>1</sup> H. Roger—Bull. de l'Acad., vol. xl., 1875, pp. 1202 and 1259. J. B. Roberts—New York Med. Journ. 1876, p. 583. Trousseau—Clinical Med., Syd. Soc. ed., vol. iii. p. 361.

<sup>2</sup> Dr. Roberts gives forty-one cases in his table, but he includes one by Dr. Bowditch, which is reported in Trousseau's Clinical Medicine. I learn, however, on personal inquiry from Dr. Bowditch, that he never performed the operation.

<sup>3</sup> Lyon—New York Medical Record, April 1, 1876, p. 221, from Med. Comm. of the Connecticut Med. Soc., 1875. Welch—American Journal Med. Sciences, Jan. 1877, p. 190, published in Trans. of Iowa State Medical Society. Hunt—London Lancet, March, 1877.



rated with fewer grave symptoms than are often caused by twelve or sixteen ounces which have been suddenly effused. Again, the effect produced by a certain amount of liquid will vary greatly in accordance with the amount of plastic exudation associated, with the condition of the muscular fibre of the heart, and with the absence or presence of pulmonary complications. Equally is it impossible to define the length of time that the operation may be delayed. In many cases even of very large effusion the symptoms, though severe, are not so urgent as to demand operative interference, and ample opportunity is thus afforded for the successful employment of milder means of treatment. In regard to this point, indeed, very much the same rules should guide us as in cases of pleural effusions. It is too much the habit of late years, since paracentesis has been rendered so easy of performance, to speak as though every case of pleural effusion called for the operation; while, in fact, although the operation is invaluable under suitable conditions, a large proportion of all such cases will do well, if not better, without it. So in cases of pericardial effusion, if the symptoms satisfy us that the liquid is purulent, we cannot operate too soon; if a large serous effusion exists, and has resisted all other means of treatment for several weeks, the operation should be performed to avoid the serious injury that may result to the heart from prolonged compression; finally, if an effusion, even of moderate extent, be productive of symptoms of urgent danger to life, the operation should not be deferred.

You will, of course, perceive that at the basis of these practical rules lies the question of an accurate diagnosis. Fortunately, in the vast majority of cases, this can be made without serious difficulty. It is indeed true that errors in diagnosis have been made even by skillful and experienced observers; but in such cases it will be found that very unusual complications or anomalous conditions existed. Certainly, if the case is an acute one, and has been under observation while the effusion formed, an accu-

rate diagnosis can readily be made. Nearly always there will have been a friction sound of cardiac rhythm, and this may persist, especially about the base, even after considerable increase in præcordial dulness from effusion has been developed. Then, carefully repeated percussion will show at first extension of dulness about the base of the heart, but soon this will be followed by a change in the shape of the area of dulness, which assumes a rudely triangular form with its base downwards, together with a decided extension of the area. If percussion be practised both when the patient is in the sitting and in the recumbent position, scarcely any difference will be observed in the horizontal level of the dulness, but if the patient be turned first to one side and then to the other, it will often be found that the area of dulness, without changing its shape, has some mobility from side to side. The position of the apex-beat of the heart will also be observed to change as the effusion occurs; it becomes raised more and more, and then becomes lost, though sometimes an obscure sense of shock can be felt over the præcordia after a distinct cardiac impulse can no longer be detected. The sounds of the heart become markedly feeble, distant, and obscure; and the centre of their greatest intensity may be observed to vary from its normal position. In addition, there may be found, in cases of very large effusion, prominence of the præcordia, slight bulging of the intercostal spaces over the heart, and even fluctuation on palpation. If the case has been under observation from the beginning, and careful attention has been paid to the above signs, a large pericardial effusion can scarcely escape detection—unless, indeed, there should coexist pleurisy with effusion on both sides, or on the left side alone. In this event it would probably be impossible to decide as to the presence or absence of pericardial effusion until the liquid had been withdrawn from the left pleural sac by aspiration. If the combined effusions were not sufficiently extensive to cause symptoms demanding operative interference, the ordinary treatment for pleurisy would suffice; while if

such symptoms did appear, as in all probability they would, it would be proper to tap the pleural sac first, after which the pericardial effusion could be easily recognized, and treated as seemed appropriate. The cases where the greatest difficulty occurs in the diagnosis of pericardial effusions are those which come under observation only after the disease has lasted some time. Here we could scarcely expect to find friction-sounds, and we would be without the valuable aid furnished by observing the progressive changes in the extent and shape of the area of dullness, and in the position of the apex-beat. We must then rely upon the prominence of the præcordia; the enlarged triangle of dullness, with its base below; the absence or altered position of the apex-beat; the distant and feeble character of the heart-sounds; the displacement of the anterior border of the lungs; and the extreme disturbance of circulation and respiration. It is true that an enlarged and dilated heart has been mistaken, and has even been tapped, in mistake, for a distended pericardial sac. But a searching investigation into the history of the case—the fact that the apex-beat, however feeble, is on the lowest level of præcordial dullness—the shape of the area of dullness, which here also is triangular, but with its base upward and to the right; and the character of the heart-sounds, which, though feeble, are much less distant and obscure than in large pericardial effusions—all of these will combine to enable a correct diagnosis to be made. Again, a solid, mediastinal tumour has been mistaken for a distended pericardium; but I am confident that close attention to the diagnostic points I have given would prevent the commission of this error. I would gladly dwell longer on this vital question, but I have only time to allude to the practical details of the operation itself. Having determined the presence of pericardial effusion, and having decided that the urgency of the symptoms demand operative interference, you must determine upon the mode of operation, and the point at which the puncture shall be made. I shall not even mention the various modes of operation that have

been recommended and practised, because I think it is beyond doubt that the safest and best method is by means of Dieulafoy's aspirating syringe, or vacuum jar. Having created a vacuum either in the jar or in the syringe, the needle is connected with it by a piece of rubber tubing; the skin is drawn from below upwards over the point selected for puncture, and the needle is then firmly pressed into the tissues. It is well to apply ice to the surface for a couple of minutes beforehand, so as to lessen pain; and if the skin is very thick, a short incision may be made through the derm to facilitate the passage of the needle. As soon as the eye of the needle is completely covered by the flesh, communication with the vacuum is opened by turning a valve or stopcock. The needle is then deliberately pressed forwards until fluid is seen to pass suddenly through the little glass index in the tube, and to enter the jar or the syringe. The needle to be used is either the smallest or the next to the smallest size. The point at which the puncture should be made has been the subject of much discussion. Of course, we desire to enter the pericardium where it is most distended with liquid, and where there is least danger of wounding the heart. Experiment and post-mortem observation have shown that in cases of large pericardial effusion the line of greatest distension of the sac is about the fifth rib; and as the apex of the heart is invariably displaced in such cases, no safer or better point of puncture can be selected than that of the normal apex-beat, *i. e.*, in the fifth interspace, about midway between the left border of the sternum and the left nipple-line. The internal mammary artery lies nearer to the sternum, and thus is in no danger of being wounded. In order to make sure of entering the pericardial sac, the point of the needle may be directed slightly upwards and inwards; or, if the effusion is evidently very large, immediately backwards. As soon as fluid is reached, the point should be turned outwards and downwards so as to lessen the risk of the heart coming in contact with it. If the precautions I

have mentioned are observed, the point of the needle may, it is true, touch the apex of the heart, but it cannot be imbedded in it, nor inflict any serious injury. In order to still further diminish this danger, I have had made a delicate double canula, the inner tube being furnished with a fine needle point. The movements of the inner tube are regulated by a button which moves along a slot in the outer tube. This canula may be introduced with the inner tube projecting, and then, as soon as the pericardial sac is entered, the sharp point is withdrawn, and we have only an ordinary blunt-pointed canula, from which no injury to the heart is to be apprehended. If, after introducing the canula to a reasonable distance, its point still feels imbedded in solid tissue, and no fluid escapes, it is probable that extensive plastic exudation exists, or that the effusion is sacculated. The canula should be withdrawn, and a second attempt may be made at a neighbouring point, or in the fourth interspace. If, after a certain amount of fluid has escaped, it begins to be largely mixed with blood, the canula should be withdrawn promptly, as the hemorrhage probably comes from the delicate new vessels of organized false membranes. If the effusion proves to be purulent, I should advise the withdrawal of as much as will flow freely, and then the injection of dilute solution of iodine; after which the canula should be withdrawn. I cannot conceive that the introduction of a drainage-tube would prove useful, or be well tolerated. I would much prefer the performance of a second paracentesis later if the pus re-accumulate.

The operation of paracentesis of the pericardium must be regarded, therefore, as a comparatively simple and safe one in cases where an accurate diagnosis of large pericardial effusion has been made. It is not likely to be followed by any unfavourable results. The effusion may collect again, but I do not believe that it would be more likely to be purulent on account of the operation having been performed. If it does not collect again, as in the case here reported, there will probably be close pericardial adhesions; but

this would equally have resulted if the effusion had been removed by absorption. I feel, therefore, that a consideration of the operation itself, as well as of its results in this case, and in the other cases on record, justifies the rules I have suggested to you in regard to its performance.

#### HOSPITAL NOTES AND GLEANINGS.

*Gout and Rheumatism.*—In a recent clinic at the London Hospital, Mr. HUTCHINSON made the following remarks on gout and rheumatism: If a man has had a sudden swelling of the great toe, with great pain, cedema, and glossiness of skin, disappearing in ten or fourteen days, you may be sure that man has had an attack of gout. The reason why it attacks the great toe (joint) is because this is the most abused joint in the body. Even when it begins to be painful, one goes on using it. The swellings of joints in gout are soft. Probably the deposit which is found here (lithate of soda) is thrown down during the inflammation. Garrod thinks it is deposited first, then excites inflammation. However this may be, if you cut into such a joint afterwards, you find the abnormal condition. Cartilage may be ulcerated away; this is rheumatic. Now, gouty people are generally rheumatic—i. e., they inherit the rheumatic (arthritic) tendency (for rheumatism is very hereditary). But the reverse does not hold—i. e., rheumatic people are not necessarily gouty; the gout is something superadded to the rheumatic diathesis. It is dyspeptic; it means mal-assimilation; it has to do with stomach, liver, and kidneys. When a gouty subject has an arthritic (i. e., a rheumatic) tendency, his gout will manifest itself in the joints; if otherwise, his joints may escape, and he may suffer only from dyspepsia, neuralgia, etc. On the other hand, give a rheumatic subject diseased kidneys, and he will very likely have gout. We see, then, that gout is in relation to the kidneys, or more generally speaking, is in relation to increase of waste matter (nitrogenous and saline in the blood). Hence gout does not neces-



sarily mean diseased kidneys. It may first be the result of altered living, or of growing old and taking consequently little exercise. Rheumatism and gout are so intimately connected, that if the subject of gout has not had rheumatism, probably his relations have. In both there must be a predisposition before some exciting cause (such as a blow on the knee in gouty synovitis, or exposure to cold in rheumatic fever) causes a manifestation of it, just as a blow on the leg will cause a node in a syphilitic subject. Rheumatism is more a nervous disease than a hæmic one. The lactic acid theory is very conjectural; it is more likely due to some spinal condition causing a multiple arthritis. The rheumatic diathesis, then, means a condition of nervous system which is highly susceptible to weather and external circumstances. It is therefore climatic. Gout, on the other hand, is dietetic, and is to be treated accordingly. Gout is frequently attended by disease of the vessels, and there is always a liability to their rupture. Hence red patches on the conjunctiva from ecchymoses, and epistaxis, are not uncommon in gout. A certain kind of retinitis, called hemorrhagic, and characterized by numerous effusions all over the retina, each one being flame-shaped, is quite pathognomonic of gout.—*Med. Times and Gaz.*, Jan. 19, 1878.

*Case of Lacerated Wound of the Knee-joint treated successfully by Lister's Method.*

—Charles W—, aged fourteen, was admitted on August 20th, 1877, into the Queen's Hospital, Birmingham, under Mr. West's care, suffering from a lacerated wound of the right knee-joint, produced by getting between some cog-wheels. The wound was on the outer side of the joint, and was about four inches long and two inches broad. The tissues around were considerably contused. The joint was opened, and two fingers could be introduced into it.

The patient was suffering from considerable shock; the hemorrhage was not severe. The wound was washed out with a solution of carbolic acid, one to ten, and dressed with Lister's antiseptic

dressing, five silver sutures being used to bring the lacerated skin as far as possible into apposition. A straight splint and an extension apparatus were applied to immobilize the limb. The wound was dressed antiseptically every day for a month, and the discharge from it continued perfectly sweet throughout, although all the contused tissues sloughed and came away. No unfavourable symptoms occurred, and the temperature, with the exception of the first two days, when it reached 100° F., remained normal, as did also the pulse and respiration.

On Sept. 28th the wound was so small and superficial that the antiseptic dressing was discontinued, and red wash used. It was then healing rapidly, was quite superficial, and was not larger than one inch by half an inch. The splint was still used, and the limb kept completely at rest. The joint was perfectly normal in size, there being no synovitis, and the outline of it was quite as distinct as that of the sound side. The patient did not complain of any pain whatever, and he ate and drank well. He could slightly flex the knee when the splint was taken off.

On Oct. 20th the wound had perfectly healed and no dressing was applied. The patient got up for the first time. He could walk very well, but the knee was kept stiff, although, when he sat down, he could flex it almost completely. There was no bony or fibrous ankylosis whatever.

*Remarks by Mr. West.*—This case is noteworthy from the absence of any constitutional disturbance after so severe an injury. Not many years ago, amputation would have been performed, so fatal was considered to be a wound of so large a joint. More especially is the case remarkable from the fact of the wound having been a lacerated one, and one in which there was more likelihood of constitutional disturbance than if the wound had been clean cut. By the adoption of the antiseptic treatment, although the lacerated tissues of a necessity sloughed and came away, so producing considerable discharge; yet there was no smell of decomposition, but everything remained

perfectly antiseptic throughout; and, from my own experience, it is in these lacerated wounds that Lister's treatment is of such very great service. The fact of there being no ankylosis, either fibrous or bony, justifies me in saying that the lad will have the perfect use of his limb.—*Lancet*, Dec. 22, 1877.

*Glycerine of Carbolic Acid as a Dressing after Ovariectomy.*—Dr. THORBURN, Obstetric Physician to the Royal Infirmary, Manchester, mentions (*Med. Times and Gaz.*, Dec. 15, 1877), a plan of dressing the wound and pedicle after the operation of ovariectomy, which he had recently adopted with marked success. The pedicle having been secured by the carbolized catgut ligature, and divided, the stump and ligature are freely smeared with the glycerine of carbolic acid of the Pharmacopœia, and returned within the abdomen. The edges of the abdominal wound, including the peritoneum, are treated in a similar manner before the wire sutures are tightened, a pad of lint soaked in the carbolized glycerine is placed over the wound and secured by a bandage, and the parts are not disturbed for ten days. Twenty-five cases of ovariectomy have been thus dealt with, and though six of the cases died, in none of the six could the fatal result be attributed, in the least degree, to septicæmia. In no instance had there been any purulent or other discharge, or any inflammatory exudation in the track of the sutures. Dr. Thorburn contended that by thus trusting the wounded parts to the undisturbed influence of the carbolized glycerine for many days, he puts to more practical proof his faith in the antiseptic virtues of carbolic acid than do those operators who examine the condition of the wound so much more frequently.

*Transfusion in Uterine Hemorrhage.*—Dr. Rossi relates (*Annali Universali di Med.*, Dec.) the case of a woman thirty-two years of age, to whom he was called on account of profuse hemorrhage coming on on the eighteenth day after delivery. In several prior labours she had uterine hemorrhage; but in the present one all

had gone on well until now, although she was in a very weakly condition. The os uteri was found to be too close to admit the finger, and hypodermic injection of ergotine and plugging were resorted to. The hemorrhage ceased temporarily, but her state of collapse became so fearful that the only doubt as to the propriety of employing transfusion was whether she was not too far gone to resort to it. However, it was resolved upon, and about 150 grammes of lamb's defibrinated blood were injected. Great reaction ensued, and after this had subsided, on a vaginal examination, a portion of placenta, the size of a crown-piece, was extracted with some difficulty. The patient eventually did well.—*Med. Times and Gaz.*, Jan. 19, 1878.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Dialyzed Iron as an Antidote in Arsenical Poisoning.*—Mr. RICHARD V. MATTISON has recently been investigating the value of dialyzed iron as an antidote to arsenic. He concludes (*Phila. Med. Times*, Jan. 5, 1878):—

1. That dialyzed iron, to be of value as an arsenical antidote, must be first precipitated by the action of some neutral or alkaline salt.

2. That this precipitation and the consequent production of ferric hydrate are accomplished when this preparation is taken into the stomach; and that, therefore,

3. The solution of dialyzed iron is a valuable antidote for arsenical poisoning, and should be administered promptly in cases of emergency as a temporary antidote, followed of course by emetics.

Now, it may readily be conceived that an antidote may be necessary in cases where the enfeebled stomach of the invalid may not be able to secrete sufficient gastric juice to precipitate the iron, even under the stimulus of the poison, or that the arsenic may be ingested into a healthy stomach entirely free from any gastric secretion.

While under these circumstances the secretion of mucus would perhaps pre-

vent absorption for a certain length of time, yet in these cases, and indeed I believe in *all* cases, the administration of dialyzed iron as an antidote for arsenical poisoning should be followed immediately by a teaspoonful or more of common salt, thus insuring the formation of the ferric hydrate and the consequent neutralization of the poison. This should at once be followed by an emetic, as the action of the ferric hydrate on the arsenic is not to coagulate it, but to form a perfectly definite chemical salt known as the arsenite of iron (ferric arsenite), which, although practically insoluble, is far from being harmless.

*Death from Chloroform.*—A young lady residing on Staten Island recently died, who had been put under chloroform and after five teeth had been extracted gave signs of recovering and was then put under chloroform again. Immediately after she was taken with a spasm; the dentist attempted to complete his work, but was compelled to desist and make an effort to save her life, but it was not successful. A post-mortem examination showed all the organs to be healthy.

*New York State Medical Society.*—The seventy-second annual meeting of this Society was convened at Albany, January 15th, Vice-President, Dr. A. L. Saunders, of Madison Co., in the chair. The attendance was good, and a number of valuable papers were presented. The following officers were elected for the ensuing year: President, Dr. D. B. St. John Roosa, of New York; Vice-President, Dr. Judson C. Nelson, of Truxton, Cortland Co.; Secretary, Dr. Wm. Maullius Smith, of Maullius, Onondaga Co.

*Medical Society of Virginia.*—The eighth annual session of this Society was held at Petersburg, Oct. 23d, 24th, and 25th, Dr. James L. Cabell, of University of Virginia, President, in the chair. Eighty-four members were registered as in attendance. Dr. Withers, on behalf of the profession of Petersburg, extended a cordial welcome to the Society. A number of interesting reports on the progress of medicine were

read as well as several scientific papers. The following officers were elected for the ensuing year. President, Dr. J. Herbert Claiborne, of Petersburg; Vice-Presidents, Drs. Wiley, of Salem, Godwin, of Fincastle, Parrish, of Portsmouth, Randolph, of Charlottesville, Love, of Winchester, and Wellford, of Richmond; Secretary, Dr. Landon B. Edwards. The next meeting will be held at Richmond.

*Louisiana State Medical Association.*—A Medical Convention convened in New Orleans on the 14th of January last, to organize a State Medical Association. Dr. S. M. Bemiss, of New Orleans, was elected temporary chairman. The roll of parishes was called, and fifteen parishes were represented by eighty delegates, and the Louisiana State Medical Association was declared organized. Dr. J. C. Egan, of Caddo, was elected Chairman. Drs. S. M. Bemiss, of New Orleans, J. W. Dupree, of East Baton Rouge, G. A. B. Hays, of Plaquemines, Vice-Presidents. Dr. Thomas Layton, of New Orleans, Secretary. Dr. Geo. K. Pratt, of New Orleans, Treasurer. Seven delegates were elected to the American Medical Association. The next meeting will be held in New Orleans on the second Wednesday of April, 1879.

*Advertisement of Medical Certificates of Nostrums, etc.*—The Comitia Minora of the Medical Society of the County of New York have adopted the following:—

*Resolved,* That for a physician to permit the use of his name, or professional reputation, in commendation of any drug, medicine, wine, mineral water, nostrum, proprietary article, or medical preparation, or of any surgical instrument or appliance whatsoever, for the purpose of advancing the pecuniary interest of any inventor, patentee, originator, discoverer, manufacturer, proprietor, or advertiser of such article or appliance, is an unworthy act.

Also, that for a physician to publish, or allow to be published in the journals, public prints, or other publications intended for the use of the laity, reports of medical or surgical cases, or papers on medical or surgical subjects, for the purpose

of attracting the attention of the general public to the author, is repugnant to the high sense of honour that should govern the medical profession.

These are the devices commonly resorted to by quacks and impostors, and have for their end the attainment of fame and notoriety by other means than those efforts in the line of professional duty which are the honourable physician's only legitimate paths to advancement in the confidence and patronage of the public.

In view of the foregoing resolutions, whereas, it has come to the notice of this Committee that certain waters—known as Apollinaris and Hunyadi Janos—also certain wines and other medical articles, are extensively advertised in the public journals and by handbills throughout the country;

And, whereas, the names of certain members of this Society appear in connection with medical certificates in said advertisements;

And, whereas, such action is in plain violation of the letter and spirit of the Code of Ethics as well as of the foregoing resolution of this Committee:

Therefore,

Resolved, That the gentlemen whose names appear on said certificates be requested to withdraw or cause the withdrawal of their names and certificates from said advertisements.—*Medical Record*, Feb. 2, 1878.

*Medical Department of Harvard University.*—President Eliot in his annual report states that the medical school has cleared, in the past three years, more than twenty-five thousand dollars over and above its expenses, which is to be reserved for future contingencies, but hereafter the annual surplus will be applied to increase the moderate salaries of the professors. Attention is called to the fact that the percentage of matriculants holding scientific degrees has risen from twenty-three per cent., which it was seven years ago, to forty-four per cent.

Preliminary examinations were held for the first time last year, and out of forty-two candidates who presented themselves twenty-seven were admitted without con-

ditions, seven with conditions, and eight were rejected. The total number of students in attendance during the past year was 247.

*New Medical Journals.*—The *Detroit Lancet* succeeds the *Detroit Medical Journal*, and Dr. Leartus Connor associates with himself Dr. H. A. Cleland in the editorial management.

*Michigan Medical News* is a semi-monthly journal published at Detroit under the editorial management of Dr. J. J. Mulheron. The first number was issued on the 21st of January, and contains twelve pages of original and selected matter.

The *Arkansas Medical Record* is a sixteen page monthly, which is published at Little Rock, and edited by James I. Hale, M.D.

*Editorial Changes.*—Dr. Galt, of the *Louisville Medical News*, has retired from the editorial chair, in which he was associated with Dr. Cowling, and Dr. L. P. Yandell, Jr., succeeds him.

*OBITUARY RECORD.*—At Louisville, Feb 4th, of pneumonia, LUNSFORD P. YANDELL, M.D., aged 73 years

Dr. Yandell was a native of Tennessee, he obtained his medical degree at the University of Maryland, in 1825. In 1831, he was elected to the chair of Chemistry in the Transylvania University and subsequently, at different times, held the chairs of Chemistry, of *Materia Medica*, and of Physiology in the University of Louisville. He was at one time editor of the *Transylvania Journal of Medicine* and afterward of the *Western Journal of Medicine*. He was the author of the address on "Medical Literature," delivered before the International Medical Congress. At the time of his death he was completing a "History of Kentucky Medicine."

#### FOREIGN INTELLIGENCE.

*Digitalis as a Diuretic.*—M. HÉRARD, during a discussion at the Société de Thérapeutique (*Journal de Thérap*, Jan. 1), stated that he administered digitalis

after maceration, this being by far the best mode. He macerates twenty-five centigrammes of coarsely powdered leaves in 200 grammes of cold water for twelve hours, and carefully strains. This is given in five or six doses, at a distance from meals, is usually very well tolerated, producing no nausea or gastralgia, and can be continued for five or six days, or longer. This twenty-five grammes should rarely be exceeded, as experience has taught him, having formerly employed much larger quantities. Given in this way the effects are often marvellous, a powerful diuresis ensuing, during which from six to ten litres of urine may be passed in the twenty-four hours, the patients being resuscitated, as it were, into a comparatively good condition. M. Bucquoy said that he preferred M. Hérard's old dose of seventy-five centigrammes, suspending the medicine at the end of four days; but M. Moutard-Martin has, like M. Hérard, diminished the doses he formerly prescribed.—*Med. Times and Gaz.*, Jan. 19, 1878.

**Abortive Treatment of Furunculus.**—Dr. LIEVEN observed at the Petersburg Medical Society (*Petersburg Med. Woch.*, Dec. 29) that all modes of treatment hitherto tried (such as early incision, cauterizing, and cold or warm applications) have failed to arrest the further development of furunculus that has once commenced. The following procedure, however, brings it to a stand: A burning, pricking, itching, suddenly occurring in a normal portion of the skin, announces the commencement of the development of the furunculus, and on the same day a small and quite superficial induration can be felt at the spot. If the skin be now superficially scraped with a small knife, so that a drop or two of blood may be pressed through the epidermis, no furunculus will be developed. This result would seem to show that the affection originates in the uppermost layer of the corium, and perhaps in the capillaries of the papillæ, and not, as hitherto received, in the subcutaneous connective tissue, with succeeding necrosis of the corium and epidermis. Disturbance of the digestive organs (fre-

quently diarrhoea) always precedes or accompanies furunculus; but a plethoric or decrepit constitution is no necessary condition, as it may occur in one that is quite normal.—*Med. Times and Gaz.*, Jan. 19, 1878.

**Injection of Perchloride of Iron in Uterine Hemorrhage.**—In a recent discussion at the Obstetrical Society of London on the value of injection of chloride of iron in uterine hemorrhage, Dr. ROBERT BARNES said the point of the syringe should be carried to the fundus. This could only be insured by introducing the hand into the uterus. Clots should be removed before injecting. One to four is a good strength, but a stronger solution might be used if necessary, but it should not be escharotic. This means of arresting hemorrhage had stood the test of experience, and had saved many lives. The test for its use is the possibility of exciting reflex action. Where this cannot be done, use perchloride of iron.—*Med. Times and Gaz.*, Jan. 19, 1878.

**Camphor-Chloral.**—Mr. W. T. TOCHER recommends the following formula for a camphor-chloral liniment, which has a powerful antineuralgic application: Chloral-hydrate and camphor, of each one ounce; glycerine, to six ounces; powder the camphor, using as usual a few drops of rectified spirit; then mix with the chloral, and allow to stand in a mortar until the mixture becomes liquid. Having poured this into a bottle, add the glycerine, and shake.—*London Med. Record*, Jan. 15, 1878.

**Inodorous Iodoform.**—Ether dissolves iodoform, and removes its disagreeable odour. If the solution be applied to a surface the ether soon evaporates, leaving behind a uniform layer of iodoform.—*Amer. Practitioner*, Jan. 1878, from *Gazette Obstetricale*.

**Typhoid Fever and Milk Supply.**—The *Lancet* (Jan. 19, 1878) gives the following particulars in reference to the outbreak of typhoid fever in Glasgow:—

In the first week of the new year it



was rumoured that typhoid fever had suddenly become prevalent in the west end of Glasgow, and that the source of infection was the milk supply of certain dairies. One or two deaths in prominent social circles intensified anxiety and made people suspicious of milk from any quarter. Inquiries subsequently begun by the sanitary staff of Glasgow allayed alarm, by localizing the contaminated milk supply to two large dairies. Though these circumstances were known, it was reserved for Dr. Russell conclusively to embody various speculations in a singularly exhaustive report, which has been presented to the Health Committee of the Town Council. He has shown that the two dairies in question were fed by a constant supply of milk from a farm where typhoid fever has existed since 1st December, "that the sanitary arrangements of this dairy were particularly defective, that the excreta of the patients were emptied into a 'grip'—i. e., a channel running on each side of the central passage provided in byres for the reception of cattle droppings." A forcing bed was thus prepared for the further development of the typhoid contagion from the heat and moisture of the other byre excreta. The water in which the various dairy utensils were washed was chiefly obtained from a well to which the contaminated sewage had percolated. Portions of this water are in the hands of the city analyst, but his report has not yet been issued. It has been ascertained at present that forty-nine cases of fever have existed among the customers of the dairies in question. Among the number of those infected were seven students who drank the milk at the refreshment room of the University, and out of these, three have already died. The facts thus ascertained by Dr. Russell, and the melancholy details attached to the fever propagation, will, it is to be hoped, lead to the proper and periodic inspection of town dairies and their country feeders. It is not pleasant to think that disease may be unwittingly brought to the doorstep every morning, through the simple medium of the most essential of all nourishing fluids for family use.

*Danger of Children's Parties.*—Dr. JOHN WHITMORE, Medical Officer of Health, in his report on the health of the parish of St. Marylebone, adds a note upon the danger of children's parties in disseminating infectious diseases, notably whooping-cough, and he gives an illustration which lately came under his notice. A lady recently gave a children's party at which some fifteen or sixteen were present; amongst them was a little boy who was observed to cough violently, and who it was afterwards ascertained was suffering from whooping-cough. Of all the children present on that occasion, it is already known that twelve have taken the disease, as well as two nursemaids who were in attendance, and two of the cases have proved fatal. Dr. Whitmore makes some opportune remarks on the mischief caused by the popular belief that whooping-cough is not infectious as well as contagious, and says that it is undoubtedly both, and therefore all children suffering from it should be isolated from others that are healthy. We confess to a strong suspicion that an erroneous belief is by no means always the innocent, because ignorant, cause of such occurrences as that commented on by Dr. Whitmore. We have met with mothers not at all scrupulous about letting their own children risk being infection-carriers rather than lose an evening's amusement, though the very slightest risk of their becoming infection-receivers through like conduct of other mothers would excite displays of temper unknown to the repose that stamps the caste of Vere de Vere.—*Med. Times and Gaz.*, Jan. 19, 1878.

*A Now Living Double Monster.*—In the *Wiener Med. Wochenschrift* for Dec. 8, Prof. HESCHL furnishes the description of an examination he has made at Vienna of a living girl, seventeen years of age, who exhibits an example of a still rarer form of monstrosity than the Siamese Twins or the Two-headed Nightingale, inasmuch as in her case the formation, in place of the upper part of the body being double as in their cases, consists in a doubling of it only below the second lumbar vertebrae, the upper portion resem-

bling that of a pleasing delicate girl of from ten to twelve years of age. The case is a specimen of Förster's *Dipyrus tetrapus*.—*Med. Times and Gaz.*, Jan. 19, 1878.

*Death from Chloroform*.—Another case of this is recorded in the *British Medical Journal* for Feb. 2.

*Death from Chloral*.—In the same journal there is reported a case of death from self-administration of an overdose of chloral.

*Chloral Hydrate a "poison."*—The Council of the British Pharmaceutical Society passed a resolution that chloral hydrate and its preparations ought to be regarded as poisons within the meaning of the Pharmacy Act. This has received the approval of the Lords of the Privy Council, and since the 14th of January it has been illegal in Great Britain for unregistered persons to sell chloral hydrate or its preparations, and it is unlawful for any persons to sell them unless the box, vessel, wrapper, or cover containing them are distinctly labelled with the name of the article and the word "poison."

*Telephonic Auscultation*.—According to the *Medical Press and Circular* the telephone has been successfully used in auscultation. It is quite possible that it may become a valuable means for class demonstration.

*Cause of Death of Victor Emanuel*.—The proximate cause of King Victor Emanuel's death was asphyxia, due to the complete arrest, from red hepatization, of the function of the right lung, the function of the left having already been impaired by the same malady. As in most of such diseases when contracted under the "malarial cachexia," there was a copious sudaminous eruption, the "miliary fever" of the Italian text-books. But this rather relieved than aggravated the symptoms, and left the cause of death, as has been stated—asphyxia. The inhalation

of oxygen, which was practised at the close, was intended to mitigate the august patient's sufferings, which by that time had become extreme.

*OBITUARY RECORD*.—At Dublin on the 7th of January, aged 74 years, WILLIAM STOKES, M.D., F.R.S.

Dr. Stokes was the most distinguished ornament of Irish medicine. He was for fifty years physician to the Meath Hospital, and of the knowledge which he gained in that position he gave liberally to the profession. He was the author of *Lectures on the Theory and Practice of Medicine, of Diagnosis and Treatment of Diseases of the Chest, of a classical Treatise on the Diseases of the Heart and Aorta*, and recently of a volume of *Lectures on Fever* which was reprinted in the Library Department of this journal, as well as of a number of contributions to various journals, etc.

— at London, on the 15th of January, aged 87, Dr. JAMES BLUNDELL, formerly Professor of Obstetrics at Guy's Hospital. Dr. Blundell was for many years a famous accoucheur and the author of a well-known work on Midwifery, published in 1834.

— at Paris, on the 18th of January, aged ninety years, ANTOINE CÉSAR BECQUEREL, Professor of Physics at the Museum of Natural History.

— at Auteuil on the 19th of January, in the sixty-eighth year of his age, HENRI VICTOR REGNAULT, Professor of Physics at the College of France, and of Chemistry at the Polytechnic School. M. Regnault was the author of an elaborate work on Chemistry.

— at Ardrea Rectory, County Tyrone, Ireland, on January 31, aged 70 years, FLEETWOOD CHURCHILL, M.D., the late distinguished Professor of Midwifery in the School of Physic of the University of Dublin, and ex-President of the King and Queen's College of Physicians. Dr. Churchill's works on "Theory and Practice of Midwifery," on the "Diseases of Women," and on the "Diseases of Children" were for a quarter of a century standard text-books on the subjects of which they treated.

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Of the many treatises on Surgery which it has been our task to study, or our pleasure to read, there is none which in all points has satisfied us so well as the classic treatise of Erichsen. His polished, clear style, his freedom from prejudice and hobbies, his unsurpassed grasp of his subject, and vast clinical experience, qualify him admirably to write a model text-book. When we wish, at the least cost of time, to learn the most of a topic in surgery, we turn, by preference, to his work. It is a pleasure, therefore, to see that the appreciation of it is general, and has led to the appearance of another edition.—*Med. and Surg. Reporter*, Feb. 2, 1878.

Notwithstanding the increase in size, we observe that much old matter has been omitted. The entire work has been thoroughly written up, and not merely amended by a few extra chapters. A great improvement has been made in the illustrations. One hundred and fifty new ones have been added, and many of the old ones have been redrawn. The author highly appreciates the favor with which his work has been received by American surgeons, and has endeavored to render his latest edition more than ever worthy of their approval. That he has succeeded admirably must, we think, be the general opinion.

We heartily recommend the book to both student and practitioner.—*N. Y. Med. Journal*, Feb. '78.

It is entirely unnecessary for us to attempt to add, by our praises, one jot to the established reputation of Erichsen's Science and Art of Surgery. It has long been a favorite text-book and authority in this country as well as in England and on the Continent, and the present edition can but add to its popularity.—*Ohio Medical Recorder*, Jan. 1878.

In revising this standard work, it will be seen that the author has spared no pains to make it worthy of a continuance of the marked favor which it has so long enjoyed, by bringing it thoroughly up to the advance in the science and art of surgery. There are about 300 pages added to the text, and about 200 wood-cuts added to the illustrations. It will maintain its position as a text-book of the medical student, and a reference book for the practitioner.—*St. Louis Med. and Surg. Journal*, Feb. 1878.

The announcement that a new edition of Erichsen's Surgery has been issued will be received with intense pleasure by all lovers of the art. The treatise, from one end to the other, has been thoroughly and conscientiously revised by its renowned author. Matter which had become obsolete in the swift advance of surgery has been left out, whole chapters have been rewritten, and every modern improvement in the art of surgery has been noted. One hundred and fifty new wood-cuts also add to the usefulness of the work in its present shape.—*Louisville Med. News*, Feb. 16, 1878.

Mr. Erichsen is already familiarly known either personally, or as an eminent authority, by nearly every American surgeon; and his statement that he has spared no effort to bring his work to the present state of our knowledge, needs no indorsement.—*New Remedies*, Feb. 1878.

HENRY C. LEA—Philadelphia.